# Feminist ethics and cultural ethos: Revisiting a nursing debate

In this article the author re-examines from a feminist perspective the now well-known debate between Yarling and McElmurry and Bishop and Scudder. The central point of this critique is that a feminist ethics requires we attend to the social and institutional form of life in which given practices exist. The endorsement of a single concept, even the extremely important one of care, is insufficient for a nursing ethics. Without attention to the institutional factors, which support or reform care, we have only a feminine ethics. In this author's view, nursing needs a feminist ethics.

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OUR ETHICAL LIVES consist of three aspects: virtue; injunctions, which are frequently referred to as duty or obligation; and a way of life, otherwise known as cultural ethos.[1,2] Virtues are excellences of character and intellect that lead to the goods of human life.[2-4] Injunctions are "those moral prohibitions or commands that people in a culture think present inviolable rights, duties, or claims."[2(p8)] They constitute the minimum set of expectations of a culture and are essential if human life is to exist at all. Because of this they are usually held to be universal, that is, to apply to all societies in all times and are frequently associated with religious requirements.[2] Cultural ethos is a complex term that includes both explicit and implicit ideals of conduct, ideology, and social and political structure and organization.[1,2] Although these elements are related

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in that injunctions serve to protect a way of life, which in turn cultivates a certain set of virtues, most of Western philosophic ethics has focused nearly exclusively on obligation or duty, what Williams[1] has called the morality system.

Philosophic work on obligation has for the most part been concerned with the nature of moral knowledge and the logical form of arguments employed to justify moral truth claims. This overattention to injunctions has formed the basis of a widespread critique of moral philosophy as well as of bioethics, the basis of which is derived from Western moral philosophy. These major nonfeminist criticisms include the following:

- traditional moral theory has a rule-based nature[5-8];
- bioethics is conflated with legality[9];
- bioethical issues tend to be limited to the immediate and direct result of the increased possibilities offered by rapid scientific and technologic advances[7,10];
- the traditional approaches aim at a stance that is impartial and disinterested; that is moral requirements are considered universal, and thus the demands of the particular situation are deemed irrelevant[5,6,11]; and
- the traditional approach fails to account for the importance of character in moral life.[7,8,12]

The overwhelming conclusion of all these critiques is that both philosophic moral theory and bioethics have failed to capture much of what is important in our ethical lives. This is especially the case for feminist theorists who agree with their nonfeminist colleagues but include the crucial and consistently ignored dimension of cultural ethos in their theories. The remainder of this article will first present a brief chronicle of both feminist ethics and nursing ethics with a view toward determining their position on cultural ethos. Secondly, it will reexamine a now classic debate within nursing ethics that highlights the problems of emphasizing a virtue ethics at the expense of cultural ethos.

## FEMINIST ETHICS

A feminist approach is defined by taking as its starting point the experience of women, by acknowledging that this experience is characterized by oppression and domination and by its open commitment to changing the practices of this oppression and domination.[13,14] According to Jaggar,[15] concern with the inferior status of women can be seen in the work of traditional philosophers, Plato, Mill, and Marx. However, Western philosophy remained virtually silent on the role of gender until the late 1960s when political activism initiated a public discourse among feminists, which then extended to academic philosophers. Jaggar tells that when these philosophers attempted to examine the social climate of the late 1960s, they found contemporary philosophic theory laced with prejudice favoring men. In her words,

> The two parallel strands of feminist ethical work—the attention to contemporary ethical issues on the one hand and the criticism of traditional ethical theory on the other—together gave rise to the term "feminist ethics," which came into general use in the late 1970's and early 1980's.[15(p81)]

Feminist ethics went beyond proclaiming that women were merely excluded from traditional philosophy; rather,

> the new view held that feminist ethics must be dedicated to rethinking the deepest issues in

ethical theory—what counted as moral issues and by what means they might properly be resolved—in light of a moral sensibility perceived as distinctively feminine.[15(p82)]

These two strands coalesced in both the public and academic consciousness with the publication of Gilligan's[16] book *In a Different Voice*. Because this work reflected the particularities of women's lives and moral experience, it represented a major challenge to traditional ethical theory. Gilligan demonstrated that the issues of moral import to women concerned the sustaining of connections essential to life and that moral problems were resolved in relation of the self to the other. Thus, care, because it arises from and reflects the very work that women do, emerged as a key concept in their moral concerns. Women care for society's vulnerable populations—children, the sick, the elderly, the retarded, the disabled. Ruddick[17] has named this work caring labor, while Reverby[18] calls it women's work. Feminist scholars from a variety of disciplines have continued to study the role of care in women's lives.

However, if attention to care has validated women's moral experience, it is also cause for serious reservation.[19-23] According to these theorists, caring labor is glorified as womanly virtue, which is taken as a category of nature rather than as an expression of a social division of labor supported by a variety of structural and political arrangements primarily serving men's needs and interests. In this way, women's caring labor is actually a powerful force in our own oppression. Thus, the concept of care has been recognized as being inadequate for a complete feminist ethics.

This can be seen more clearly when we recall that injunctions protect a way of life, which in turn picks out certain virtues. In this case, injunctions such as, "good women are not aggressive or do not get angry" protect a form of life in which men benefit from the public and private distinction of social control and participation by rewarding the behavior of traditional womanly virtues. Those theorists supporting the voice of care emphasize the virtue aspect[24] of the ethical triad, while those who focus on the structural and political arrangements underscore the importance of cultural ethos. One can hear the distinction in the words of Card: "Feminist ethics is born in women's refusal to endure with grace the arrogance, the indifference, hostility, and damage of oppressively sexist environments."[19(p4)]

Feminist philosophers are clear on the essential role of cultural ethos to a feminist ethic. Sherwin[22] has argued that regardless of the importance of a particular moral concept to women, unless philosophers give serious attention to the patterns of oppression against women in society, they are doing feminine ethics and not feminist ethics. Jaggar states that:

> . . . even though the project of feminist ethics must include a reevaluation of what has been constructed as feminine, and possibly even a rehabilitation of some aspects of it, this cannot be done in an uncritical way. Although feminist ethics may begin with feminine ethics, it cannot end with it.[15(p92)]

## NURSING ETHICS

The discipline of nursing ethics was initiated at the same time as the term feminist ethics was coined with the publication in 1978 of Davis and Aroskar's book *Ethical Dilemmas in Nursing Practice*.[25] This work is important because it is transitional in several ways. First, as the authors note in the

preface, the literature on nursing ethics prior to this publication reflected the view of ethics as restricted to either legality or etiquette. Second, they introduced nursing to the traditional principle-based approach dominant in moral philosophy and also beginning to be taken up by medicine. Third, although they talked largely of ethical dilemmas, such as abortion, informed consent, and issues related to death and dying, which is typical in this approach, they called attention to the idea that these dilemmas occur within the context of nursing practice. Their claim was that there is something about the nature of nursing practice that casts a different light on traditionally conceived health care dilemmas; as such, they implied that nursing ethics was not reducible to medical ethics. Fourth, Davis and Aroskar discussed institutional constraints on nursing practice, thereby anticipating some of the major feminist criticisms to come.

Following Davis and Aroskar, a helpful discourse ensued in which nursing scholars sought to delineate the ethical foundation of our practice.[26-32] These authors are in general agreement that the moral basis of nursing practice lies in the relationship between the nurse and the patient. Patient advocacy within a caring relationship is the vehicle by which the moral basis is made manifest. The centrality of care to nursing practice was raised in the late 1970s in the work of Leininger[33] and Watson,[34] with Carper[27] explicitly calling attention to the ways our ethics are embedded in our caring. Since that time, the ethic of care has been the dominant voice in nursing ethics,[24,35-37] but as in feminist ethics, it has its critics[38] and its cautionary supporters.[39] When two authors explicitly addressed cultural ethos, they met with an answer that highlights the inadequacies of an emphasis on virtue ethics at the expense of our forms of life.

## DEBATE

In their provocative and now classic paper, "The Moral Foundation of Nursing," Yarling and McElmurry[30] argued that nurses were not free to be moral; a claim they acknowledged was first raised by Davis and Aroskar.[25] Yarling and McElmurry were very clear in stating that what they meant by free was not "a reference to transcendental freedom of the will, for freedom in this sense is a necessary condition of even being a moral agent and having moral problems."[30(p63)] Rather, free referred to "freedom of action in the sense that acts are free from unforced choice."[30(pp63,64)] Furthermore, they qualified their conclusion by restricting it to those nurses who practiced in hospitals, which are hierarchically organized and not controlled by nurses. Just as with their colleagues discussed above, Yarling and McElmurry agreed that the basis for a nursing ethic should be the nurse–patient relationship; however, they concluded that the nature of the hospital organization consistently undermined that relationship. This resulted from conflicts between the hospital's end of "institutional maintenance"[30(p65)] and the nurse's commitment to the needs of a particular patient. For Yarling and McElmurry, "at stake in the conflict, for nurses, is nothing less than the nurse–patient relationship . . . it is the necessary foundation for a nursing ethic."[30(p65)]

The authors[30] noted that nursing's primary commitment to the patient as distinct from the hospital is a relatively recent historic phenomenon. Because of this, Yarling and McElmurry forcefully argued that a strong sense of professional autonomy and a

shift in accountability from physician to patient were necessary, although not sufficient, conditions for nurses to be moral. It is important to note that when the authors speak of professional autonomy they are not referring to the notion of radical individualism with which the word autonomy has frequently come to be associated. Instead, they are arguing for the autonomy of nursing as a practice, that is, for practitioners who are free from unforced choice to act on behalf of their patients. In their words,

> The moral situation of nurses is most poignantly revealed when they perceive that the right to freedom and well-being of patients in their care and treatment is threatened or violated by a physician, another nurse, or some other health care provider for whom the hospital is responsible. . . . The moral predicament of nurses arises from their commitment to patients, and that commitment is grounded in nurses' status as moral agents. Were nurses simply the instrument of those around them, as they are often assumed to be, then they would have no moral problem and no sense of not being free.[30(p64)]

Although the aim of this article is not a critique of contemporary understandings of autonomy, it is necessary to discuss it in some detail since that is how the authors in question have framed their debate. Philosopher Bruce Miller[40] discussed the four senses of autonomy in contemporary philosophy. In this explication he drew on the work of several philosophers including Beauchamp and Childress, Dworkin, Englehardt, Callahan, Frankfurt, and C. Taylor. These four senses include autonomy as

1. free action,
2. authenticity,
3. effective deliberation, and
4. moral reflection.[40]

According to Miller,

> autonomy as free action means an action that is voluntary and intentional. An action is voluntary if it is not the result of coercion, duress, or undue influence. An action is intentional if it is the conscious object of the actor. . . . Autonomy as authenticity means that an action is consistent with the person's attitudes, values, dispositions, and life plans. Roughly, the person is acting in character. Autonomy as effective deliberation means action taken where a person believed that he or she was in a situation calling for a decision, was aware of the alternatives and the consequences of the alternatives, evaluated both and chose an action based on that evaluation. . . . Autonomy as moral reflection means acceptance of the moral values one acts on.[40(pp24,25)]

Miller argues that an action must be autonomous in the first sense if there is to be a coherent understanding of autonomy in any of the other senses. According to Miller's analysis, it is clear that Yarling and McElmurry are using autonomy in the first sense of voluntary and intentional action. Yarling and McElmurry do not absolve nurses from their responsibility to act morally, indeed, "their responsibility is inescapable" but,

> the principle indictment is intended for those institutional structures that systematically create formidable obstacles to responsible action . . . they must be held responsible for the suppression of the moral impulse in everyday life.[30(p71)]

They conclude "that *a responsible ethic must be a social ethic,*" that is, *an ethic concerned with "structures and policies of social institutions."*[30(p71)] [emphasis added]

These authors offered two solutions. First, they noted the history of nurses as social reformers and argued that such an appeal to our own historical tradition is absolutely necessary if "nursing ethics is to become more than a footnote on medical ethics."[30(p72)]

Their second solution is far more radical; if nurses cannot obtain more power in hospitals, they must "terminate its employee status with the hospital, move outside the hospital, and serve hospital patients from the vantage point of some new nursing-controlled organization."[30(p72)]

Finally, it can be said that Yarling and McElmurry anticipated some of the feminist critiques discussed in the previous section in claiming that bioethics "has been staunchly nonreformist. In a word, medical ethicists have explicitly disclaimed any interest in reform."[30(p72)]

In their 1987 essay "Nursing Ethics in an Age of Controversy," Bishop and Scudder[31] responded to Yarling and McElmurry with a moral stance based on a view of the nurse as the "in-between" person charged with the day-to-day activity of the patient. They are not unique in viewing nurses as the "in-between" health care professional; philosophers MacIntyre[41] and Englehardt[42] have also offered accounts of this position. In answering Yarling and McElmurry, Bishop and Scudder make three arguments.

First, from their perspective, nursing practice is care that stands in sharp contrast to the medical world of cure. Bishop and Scudder accused Yarling and McElmurry of buying into the medical model of cure as well as advocating yet further specialization. Although they are not explicit as to what this endorsement of cure actually looks like in practice, they conclude that the consequences are twofold; first, the practice of caring will disappear as nurses become merely technicians in the service of medicine's curing practices; and secondly, this specialization will demand that nurses compete with other health care professionals to define an area of expertise that will then require that nurses "reform health care policy and practice."[31(p35)]

The second criticism Bishop and Scudder offer is their charge that Yarling and McElmurry operate "within the context of traditional philosophical moral decision making."[31(p35)] For Bishop and Scudder, this means that Yarling and McElmurry focus on autonomy, which is viewed as equivalent to a principle-based applied ethics. Furthermore, reform of the health care system is somehow dependent on the concepts of cure and autonomy and thus seen as coming under the province of traditional health care ethics, which they reject. While virtue ethics is anything but novel, it is now enjoying a renaissance after a long dormant period in Western ethics. That Bishop and Scudder are committed to a virtue ethics is evident in their accusation: "they [Yarling and McElmurry] contend, that nurses need to be less concerned with traditional personal ethics and more focused on reform of the system."[31(p36)]

The third argument that Bishop and Scudder present is a view of ethics based on what they call the moral sense of nursing. This is a phenomenologic perspective that attends to the lived moral experiences of nurses. In this view, the work of care is the essence of nursing and permits nurses access to what they call the in-between position. According to Bishop and Scudder,

> In our desire for nursing autonomy, however, we cannot ignore the moral stance already present in nursing, the opportunities to reform health care from within, and the privileged in-between position of nurses in reaching moral decisions.[31(pp35,36)]

By in-between they mean that nurses occupy the nexus of connections between phy-

sicians, patients, and hospital bureaucrats. Expert nursing practice establishes and sustains this nexus, thereby fulfilling the moral sense of nursing. The expert practice of this moral sense confers what the authors term legitimate authority, which is manifested in the day-to-day realities of ethical practice.

## CRITIQUE AND DISCUSSION

Yarling and McElmurry raise a very serious ethical question in asking if nurses working in hierarchical, nonnursing controlled institutions are free from coercion to act on behalf of their patients. They hold that the nurse–patient relationship is the moral focus of nursing practice but see the interests of institutions as threatening the very fabric of that focus. They recognize that nurses may pay a very high price for acting in the interests of their patients against institutions. While they do not absolve nurses from the responsibility of so doing, they do challenge the morality of those oppressive and domineering practices. The three themes that underlie all the arguments put forth by Bishop and Scudder are:

1. care versus cure,
2. the concept of autonomy, which they take as signifying traditional principle-based ethics, and
3. the in-between status of nursing practice.

### Care versus cure

It is not clear how Bishop and Scudder see Yarling and McElmurry as buying into a medical model of cure. Even if the former authors had been explicit, they make far too great a distinction between care and cure than is actually warranted in practice. It is certainly the case that on a cultural level we are highly biased in favor of cure. After all, biomedic research receives much more money than do services aimed at delivering care. And the proposal that this inequity be addressed by public policy is heartily supported by this author. However, at the level of practice, this sharp distinction simply does not hold, as others have shown.[35,41] Bishop and Scudder make it sound as if only nurses care and only physicians cure; this is an unhelpful and false dichotomy. The authors mention nursing's tradition of care but fail to acknowledge that this care has historically been defined by others, namely physicians.[18,41,43] As MacIntyre writes,

> For a very little consideration makes it clear that nursing has been defined residually; to the nurse has been allocated whatever has been left over from the often self-defined functions and tasks of the physicians and surgeon and the bureaucratically defined tasks of the hospital administrator.[41(p79)]

Furthermore, their belief that advances in medical science will make curing technicians of nurses seems to point to a belief in medical progress that is not warranted. Medicine has indeed made several advances, but the result has been a dramatic increase in chronic illness—just those patients who need care.

Bishop and Scudder are as nonreformist of the health care establishment as the feminist ethicists find both medicine and bioethics to be.[22,44] As noted earlier, their reasoning is that autonomous nursing practice will result in competition with other providers and require reform. This reference to a fear of competition appears self-serving; certainly, fears of competition have fueled political action on the part of organized medicine to protect their social control and

privilege from both nurse and lay encroachment.[22] This section concludes by asking Bishop and Scudder if there were no other rationale that would license reform.

### Autonomy and traditional ethics

This is clearly a central point for Bishop and Scudder who come from a philosophic tradition that questions the term in Miller's fourth sense, that is, autonomy as moral reflection. This position takes issue with our contemporary cultures' focus on radical individualism. From this point of view, we are born into certain traditions that impart values to us—we do not choose them on our own. Among aspects of Bishop and Scudder's response that are confusing is that they ignore Yarling and McElmurry's opening premise where they state quite clearly they are not talking about transcendental freedom of the will. This means that one's will or intention is completely unaffected by any other factors accept the requirements of universal, rational morality.[45] In other words, no other fears, concerns, or practical realities have any effect on our willing a particular action. This disavowal is what makes freedom of the will transcendental. One can imagine how this notion might not work ideally in everyday life.

Bishop and Scudder say that for Yarling and McElmurry,

> autonomy becomes a necessary condition for acting morally. Thus Yarling and McElmurry conclude that nurses lack sufficient autonomy to be moral agents. To support their position, they usually choose examples in which the nurse acts in behalf of the patient in tension or conflict with physicians or hospital bureaucrats. Since *in these examples nurses obviously lack autonomy*, Yarling and McElmurry contend that nurses can truly be moral agents only when the health care system has been reformed so that nurses can act as autonomous individual professionals.[31(p36)] [emphasis added]

This response is confusing. Here Bishop and Scudder are clearly indicating their agreement with Yarling and McElmurry, yet go on to reproach them for suggesting health care reform that includes an autonomous nursing profession. This contradiction regarding autonomy is evident in their other work as well. By now, it should be abundantly clear that Bishop and Scudder do not like the word autonomy when applied to nurses. Yet, supporting autonomy in patients has central import in the practice of nursing and pervades our ethical language, even for Bishop and Scudder. In their book *The Practical, Moral, and Personal Sense of Nursing*, they refer in several places to notions of autonomy regarding patients; for example, the duty to "respect" patients as persons[24(pp12,172)]; patients must be "willing"[24(p27)]; and "illness results in a surrender of one's autonomy."[24(p35)] These are words that in both everyday and philosophic discourse are associated with ideas of autonomy and traditional Kantian ethics, yet they do not criticize nurses in these instances. The implication of this is that while nurses must safeguard the autonomy of others, they may not demand it for themselves. This is profoundly disturbing to the author, even more so when the work of care is set in opposition against reform of the institution in which this care takes place.

Bishop and Scudder see Yarling and McElmurry as endorsing traditional ethical theory; there are three ways to respond. First, while a given ethical approach does influence what counts as a moral problem, it is not seen why inequities of power and status leading to oppression and domination would not count as a moral problem on

Bishop and Scudder's philosophic system. If this truly is the case, it is a dangerously conservative ideology. Secondly, it is certainly true that Bishop and Scudder, in emphasizing the importance of care, are advocating a moral stance that moves beyond traditional ethics. However, it is Yarling and McElmurry who, in emphasizing the oppression and domination of nurses in our cultural ethos, assume a feminist stance and thus move far beyond any traditional approaches. As Sherwin[22] and Holmes[44] indicate, no one in mainstream bioethics has addressed this to date; the institution of medicine is simply taken as a given. Thirdly, because Bishop and Scudder's philosophic perspective is one in which one's environment shapes the person, one would think they would have more sympathy for Yarling and McElmurry's position.

**The in-between position**

As mentioned in an earlier section, Bishop and Scudder present a view of ethics based on what they call the moral sense of nursing, which arises from the day-to-day experiences of nurses. In this view, the work of care is the essence of nursing and serves to locate nurses and their work at pivotal junctions between physicians, patients, and hospital bureaucrats. Bishop and Scudder call this the in-between position. Expert nursing practice establishes and sustains these connections, thereby fulfilling the moral sense of nursing. The expert practice of this moral stance confers what the authors term legitimate authority. In their book, Bishop and Scudder say, "when treated contextually, what they call autonomy would be more appropriately designated legitimate authority."[24(p129)]

The notion of an in-between position as presented by Bishop and Scudder cannot be accepted from a feminist perspective. If they had presented the concept in the way that MacIntyre[41] does, it would be acceptable. In his case, nurses act as interpreters between the worlds of clinical medicine and the lived experience of illness. Bishop and Scudder, however, seem to use the notion differently. In their description, nurses do the work of sustaining the complex network of hospital relationships, but it is work that is often overshadowed, silenced, and made invisible.

Finally, Bishop and Scudder do not provide an account of how legitimate authority works in situations of breakdown. In other words, what is to be done and what can be appealed to when authority becomes illegitimate?

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This debate clearly illustrates how each side frames the issues. For Bishop and Scudder,[24] nursing ethics is limited to virtue ethics in that the competencies of expert caring are virtues. Yarling and McElmurry's rationale[30] for reforming our health care institutions and practices meets with a chastisement usually rendered by the not-so-subtle misogynists who reprimand and punish women for demanding independence. On the other hand, Yarling and McElmurry highlight the necessity of reforming our institutions exactly because they can stifle and deform care. In taking this approach, they include a role for virtue but recognize that our way of life selects certain virtues. The traditional womanly virtues have been those that have ensured we knew our place and kept it "with grace."

Surely it has never been more urgent that we pay the closest attention to our cultural ethos. We are now 50 years away from Nazi atrocities, one of the most institutionalized

forms of violence the world has known, and we are now only beginning to face our complicity in this evil. Steppe,[46,47] Johnstone,[48] Proctor,[49] Lifton,[50] and Davis[51] have begun to explore the role of nurses in this horror. Their work shows that nurses cared tenderly as they packed the belongings of their psychiatric patients on the way to be killed. They undressed them gently and comforted them even as they led them into the gas chambers. What are we to make of this? These nurses were surely exhibiting the virtues of a form of life. But there are also those nurses who resisted.[50,52,53] What can be said about their virtues? Feminist ethicists pose the essential questions. In the words of Card,

> Feminist ethics interests me especially in relation to problems of agency under oppression. If oppressive institutions stifle and stunt the moral development of the oppressed, how is it possible, what does it mean, for the oppressed to be liberated? What is there to liberate? What does it mean to resist, to make morally responsible choices, to become moral agents, to develop character?[19(p25)]

To answer these questions, Card believes feminist ethics must attend to four needs: agency in oppressive contexts, modes of resistance, articulation of ideals, and the need to be watchful of "becoming what we despise."[19(p26)]

Nursing ethics needs the same—we need a feminist ethics.

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